NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Virtual Meeting

Health Innovations (B) Working Group
Friday, June 20, 2025
1:00 – 2:00 p.m. ET / 12:00 – 1:00 p.m. CT / 11:00 a.m. – 12:00 p.m. MT / 10:00 – 11:00 a.m. PT

ROLL CALL

Marie Grant, Chair	Maryland	Chrystal Bartuska	North Dakota
Amy Hoyt, Vice Chair	Missouri	Daniel Bradford	Ohio
Anthony L. Williams	Alabama	TK Keen	Oregon
Sarah Bailey/Jeanne Murray	Alaska	Carlos Vallés	Puerto Rico
Debra Judy	Colorado	Rachel Bowden/	Texas
Howard Liebers	District of Columbia	R. Michael Markham	
Alex Peck	Indiana	Tanji J. Northrup	Utah
Andria Seip	Iowa	Kim Tocco	Washington
Julie Holmes	Kansas	Joylynn Fix	West Virginia
Robert Wake	Maine		
Viara Ianakieva/	New Mexico		
Margaret Pena			

NAIC Support Staff: Joe Touschner

AGENDA

1. Consider Adoption of Its April 24, 2025 Minutes—*Marie Grant (MD)*
   Attachment 1

2. Hear a Presentation on Health Care Choice Compacts under Section 1333 of the Affordable Care Act—*Marie Grant (MD)*
   - Peter Nelson (Center for Consumer Information and Insurance Oversight)

3. Hear Presentations on State Experiences with Flexibility under Sections 1331 and 1332 of the Affordable Care Act—*Marie Grant (MD)*
   - Weston Trexler (Idaho)
   - Clare Pierce-Wrobel and Jesse O'Brien (Oregon)

4. Discuss Any Other Matters brought before the Working Group—*Marie Grant (MD)*

5. Adjournment

Draft: 5/12/25

Health Innovations (B) Working Group
Virtual Meeting
April 24, 2025

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met April 24, 2025. The following Working Group members participated: Marie Grant, Chair (MD); Sarah Bailey (AK); Debra Judy (CO); Andria Seip (IA); Alex Peck (IN); Julie Holmes (KS); Robert Wake (ME); Viara Ianakieva (NM); Daniel Bradford (OH); Andrew R. Stolfi (OR); R. Michael Markham (TX); Tanji J. Northrup (UT); and Joylynn Fix (WV). Also participating was Weston Trexler (ID).

1. Heard Presentations on State Flexibilities Under the Affordable Care Act

Grant reviewed the Working Group's plans for the year. She said the current meeting would review state flexibilities under the Affordable Care Act (ACA), and the next meeting would allow states to speak about their experiences using the flexibilities. She said the Working Group plans to meet in person at the Summer National Meeting and subsequently complete work on a white paper that can be shared with the B Committee and other regulators.

Sabrina Corlette (Georgetown University Center for Health Insurance Reforms—CHIR) presented on basic health programs (BHPs) under ACA Section 1331. She said basic health programs replace Marketplace plans for individuals up to 200% of the federal poverty level. The federal government pays states 95% of the amount eligible individuals would have received in premium tax credits in the absence of a BHP. Any surplus of funds must be reinvested in the program. Corlette said the federal government reviews states' blueprints for BHPs, but there is limited statutory discretion for the Secretary of Health and Human Services (HHS) to disapprove an application.

Corlette said that until 2023, Minnesota and New York were the only states with BHPs. Since then, New York transitioned its BHP to a Section 1332 waiver, and Oregon added a BHP. She said that BHPs made fiscal sense for Minnesota and New York because prior to the ACA, both states were using state funds to cover similar populations. She said both Minnesota and New York build BHPs on Medicaid with provider payments and coverage based on Medicaid. She said both states offer benefits beyond the requirements of federal law. She said New York covered its entire program cost with federal funds, while in some years, Minnesota had to add a share of state funds.

Corlette said BHPs can be a cost-effective method of providing coverage to low-income residents, but cost-effectiveness depends on benefit design and market conditions. She said BHPs can aid with continuity of care for individuals transitioning from Medicaid. Challenges with BHPs include increased costs for Marketplace enrollees and changes in provider access for individuals who move from Marketplace plans to BHP. She added that any federal changes that reduce the funds available for premium tax credits also reduce the funding for BHPs.

Corlette said BHPs interact with the rest of the individual health insurance market. She said that, because of the added costs on silver-level plans due to cost-sharing reductions, BHPs can reduce the premium tax credits available for Marketplace enrollees with income above 200% of the federal poverty level. She said that because BHPs shrink the size of the individual market, it can make it less appealing for insurers to offer plans in the individual market. She said the effects of BHPs on the risk pool vary market to market and state to state.

Corlette said an important consideration for states is whether there is a large difference between provider payments in Medicaid and in the individual market. She said analyses have shown that the cost-effectiveness of

BHPs varies quite a bit based on this difference, with more cost-effectiveness when there is a large difference in payment levels.

Dan Meuse (State Health and Value Strategies) presented on state innovation waivers under Section 1332 of the ACA. He said that BHPs are a ready-made solution, and by contrast, Section 1332 is a tool for states to achieve a policy goal. It provides an opportunity to do something different from what is laid out in the ACA and its regulations.

Meuse said changes a state makes under Section 1332 must meet four guardrails, including coverage, affordability, scope, and deficit neutrality for the federal government. He said the approval process includes a review of whether a state's program meets the guardrails. He said states must identify a law they would waive under Section 1332.

Meuse said a key feature of Section 1332 is pass-through funding. He said these are any funds a state's waiver saves from federal spending on premium tax credits. These funds are passed through to the state and can be spent on the state's waiver program.

Meuse said most states with Section 1332 waivers have reinsurance programs, with 19 implementing reinsurance alone and four states with reinsurance in addition to another waiver provision. He said the ACA created a national reinsurance program that ended in 2017. He said at that time, several states had carriers looking to leave the individual market and others with high variability in prices, as well as some states with a risk of counties without any individual market plans. He said reinsurance creates an environment where premiums are more predictable. He said the majority of reinsurance costs are covered by pass-through funds, though nearly all programs require some state funding.

Meuse described the public option plans operated under Section 1332 waivers in two states. He said Colorado and Nevada require certain plans to meet premium reduction targets and other standards. He said Maryland and Washington allow the purchase of Marketplace plans regardless of immigration status. He said Georgia developed a waiver plan to offer plans without a Marketplace, but this portion of its waiver is suspended, leaving only a reinsurance program. Meuse said Hawaii's waiver allows the state's pre-ACA employer mandate requirements to remain in effect. He said New York has the largest waiver, which allows individuals under 250% of the federal poverty level to participate in an expanded BHP.

Meuse said an end to enhanced premium tax credits will lower state pass-through amounts. He said lower enrollment in Marketplace plans due to the 2025 Marketplace Integrity and Affordability Proposed Rule would also lower pass-through amounts. He said Section 1332 waivers do not increase pass-through amounts because they enroll more individuals. He said potential new guidance from the Trump administration could change the policy priorities that receive approval as a state waiver.

Seip asked about Hawaii's Section 1332 waiver. Meuse said Hawaii has a unique situation because in the 1970s, it passed a mandate for private employers to offer health coverage. Its mandate requirements conflicted with small group requirements under the ACA, so the state sought a waiver of the ACA requirements. He said with the waiver, the state can continue to operate its employer mandate and receive a small amount of pass-through amounts due to federal savings on small business tax credits.

Randy Pate (Randolph Pate Advisors) presented on interstate health care compacts under Section 1333 of the ACA. He said HHS has not issued regulations under Section 1333 even though the ACA contemplated regulations by 2012. He said the section allows the sale of health insurance across state lines.

Pate said states may want to consider Section 1333 compacts because they offer greater flexibility and decision-making authority for states. He said they also offer greater stability in regulations because a state-level compact will be insulated from changes in federal administrations.

He said a compact must first be enacted under state law. It must comply with guardrails similar to the Section 1332 guardrails. Additionally, a Section 1333 compact may not weaken state consumer protection laws. He said that Section 1333 is under a constitutional foundation different from Section 1332, so the compact could be considered to have the force of federal law, depending on how regulations are written. He added that Section 1333 compacts do not have a statutory term limit, in contrast with the maximum five-year terms of Section 1332 waivers.

Pate said Section 1333 compacts could accomplish most of the policy changes that could be pursued under Section 1332. He cited examples of changing the premium tax credit structure, using flat or age-adjusted credits, or implementing reference-based pricing as part of the tax credits. He said states could also take a more minimal approach, such as by addressing network adequacy requirements. He said many other ideas are possible, such as specialized plans for chronic conditions or changes to actuarial value levels.

Pate said the Trump administration or a future one could issue regulations under Section 1333. The regulations could be minimal, defining the statutory guidelines, or they could be more extensive and provide templates for states to follow in adopting a compact. He said federal policymakers would need to decide whether to interpret the guardrails as they have under Section 1332 and how pass-through funding would work. Pate said a state interested in a Section 1333 compact would need to find one or more like-minded states to work with and develop administrative capacity. He said the current director of the Center for Consumer Information and Insurance Oversight (CCIIO) authored a paper on Section 1333 compacts last year, so it will be interesting to see whether there is a proposed rule under this administration.

Trexler asked whether states can move forward before regulations are issued in consultation with the NAIC. He also asked whether the Internal Revenue Service (IRS) would be able to administer a different tax credit structure for states with a Section 1333 compact. Pate said consultation with the NAIC is required under the statute, so it would need to take place first. He said it is early in the administration, so there is still an opportunity for consultation and issuing regulations. He said the IRS has limited ability to administer different versions of the premium tax credit, but that could change over time. He said an alternative approach is for compacting states to administer the tax credits using pass-through funds. Grant said the Working Group should consider the key issues for the NAIC to bring to any consultation regarding Section 1333 regulations.

Grant asked whether a Section 1333 compact could be paired with a Section 1332 waiver to achieve more ambitious changes. Pate said the two authorities could be paired. He said Section 1333 allows compacting states to alter rules for qualified health plans, without further definition on what can be done. He said regulations would be important in providing further definition. Amy Killelea (Consumer Representative) urged regulators to consider the impact on consumer protections under any of the state flexibilities. She said the federal floor of protections has been important and should be maintained.

Having no further business, the Health Innovations (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/B CMTE/Health Innovations/Minutes 4.24

